PRINTED: 05/02/2012 FORM APPROVED

CENTERS FO	OMB NO. 0938-0391					
STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155329		IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 04/16/2012	
NAME OF	NAME OF PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
ROSEWALK VILLAGE AT INDIANAPOLIS			I LESLEY AVE NAPOLIS, IN 46219			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
K0000	State Licensure the Indiana State accordance with Survey Date: 04 Facility Number Provider Number AIM Number: Surveyor: Mark Code Specialist At this Life Safe Rosewalk Villag found not in corn Requirements for Medicare/Medic 483.70(a), Life 2000 edition of Protection Asson Safety Code (LS)	er: 000222 er: 155329 100274950 c Caraher, Life Safety ety Code survey, ge at Indianapolis was	K0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 5/4/11.		
	be of Type V (0 sprinklered. The	acility was determined to 00) construction and fully e facility has a fire alarm bke detection in the				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

corridors and in all areas open to the corridor. Battery operated smoke

> TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

083621

Facility ID: 000222

PRINTED: 05/02/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155329	(X2) MULTIPLE CC A. BUILDING B. WING	01	COMPLETED - 04/16/2012
	PROVIDER OR SUPPLIER ALK VILLAGE AT INDIANAPOLIS	1302 N	ADDRESS, CITY, STATE, ZIP CO LESLEY AVE IAPOLIS, IN 46219	DDE
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETION
	detection is provided in all resident sleeping rooms. The facility has a capacity of 182 and had a census of 151 at the time of this visit.			
	Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/19/12.			
	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 083621

Facility ID: 000222

If continuation sheet

Page 2 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155329		A. BUII	LDING	onstruction 01	(X3) DATE S COMPLI 04/16 /3	ETED	
	ROVIDER OR SUPPLIER		B. WIN	1302 N	ADDRESS, CITY, STATE, ZIP CODE LESLEY AVE APOLIS, IN 46219		
(X4) ID PREFIX TAG K0038 SS=E	SUMMARY ST (EACH DEFICIENCE REGULATORY OR NFPA 101 LIFE SAFETY Concept Exit access is an readily accessible with section 7.1. 1. Based on obset the facility failed egress through 1 in the Therapy Response accessible for rest LSC 7.2.1.6.1, Desays approved, it locks shall be performed by an approved, supervised automost in building the section system with Section 9.6, supervised automost installed in accordant where permit through 42, prover adjacent to the response to the rest of the response to the	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ODE STANDARD ranged so that exits are e at all times in accordance 19.2.1 ervation and interview, to ensure the means of of 1 delayed egress locks oom was readily sidents, staff and visitors. elayed Egress Locks, sted, delayed egress rmitted to be installed on v and ordinary hazard ings protected throughout supervised automatic fire installed in accordance or an approved, natic sprinkler system dance with Section 9.7, tted in Chapters 12 ided that: (d) On the door elease device, there shall he, durable sign in letters ch high and at least 1/8 dth on a contrasting reads: LARM SOUNDS.	K00	INDIAN ID PREFIX TAG		e	(X5) COMPLETION DATE 05/08/2012
	exit.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 083621

Facility ID: 000222

If continuation sheet

Page 3 of 13

PRINTED: 05/02/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155329		LDING	NSTRUCTION 01	(X3) DATE COMPL 04/16/	ETED	
	PROVIDER OR SUPPLIER		1302 N	DDRESS, CITY, STATE, ZIP CODE LESLEY AVE APOLIS, IN 46219		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) :	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	: IATE	(X5) COMPLETION DATE
	Based on observed Maintenance Supthe facility from on 04/16/12, the is equipped with which was provided the door could be by pushing on the application of for within 15 second not release within door was pushed force two separar Room exit door or released when the at 1:13 p.m. on 00 interview at the the Maintenance Supthe Therapy Room with a delayed exprovided with sign could be opened on the door with to the release deviated but the exit door seconds when the the application of times. 3.1-19(b)	ation with the pervisor during a tour of 11:10 a.m. to 1:35 p.m. Therapy Room exit door a delayed egress lock ded with signage stating e opened in 15 seconds				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 083621

Facility ID: 000222

If continuation sheet

Page 4 of 13

PRINTED: 05/02/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 155329	(X2) MULTIPLE CO A. BUILDING B. WING	01	04/16	SURVEY LETED 5/2012		
	PROVIDER OR SUPPLIER ALK VILLAGE AT INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE		
	the facility failed to ensure the means of egress through 1 of 11 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice affects any resident, staff or visitor needing to exit the facility by Room 123. Findings include: Based on observation with the Maintenance Supervisor and the Executive Director during a tour of the facility from 11:10 a.m. to 1:35 p.m. on 04/16/12, eleven exit doors were magnetically locked and could be opened by entering a four digit code but the code was not posted at the exit door by Room 123. The exit access by Room 123 has two exit doors in series in the path of egress which each could be opened by						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 083621

Facility ID: 000222

If continuation sheet

Page 5 of 13

PRINTED: 05/02/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	01	(X3) DATE SURVEY COMPLETED	
	155329	A. BUILDING		04/16/2012	
		B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER		LESLEY AVE		
ROSEWA	ALK VILLAGE AT INDIANAPOLIS	INDIAN	APOLIS, IN 46219		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC1)	DATE	
	entering a four digit code but the code was not posted at the second exit door				
	which discharged directly to the exterior				
	of the building. Based on interview with				
	the Executive Director at the time of				
	observation, approximately 50 % of the				
	residents do not have a clinical diagnosis				
	to be in a secure building. A resident				
	without the clinical diagnosis requiring				
	specialized security measures would have				
	to ask a staff member to let them out if				
	they did not know the exit access code.				
	The delayed egress lock on the exit door				
	by Room 123 which discharges directly to				
	the exterior of the building released when				
	the fire alarm was activated at 1:13 p.m.				
	Based on interview at the time of				
	observation, the Maintenance Supervisor stated the four digit exit code was not the				
	same code for each exit door and				
	acknowledged the four digit exit code was				
	not posted at the second exit door which				
	discharged directly to the exterior of the				
	building.				
	3.1-19(b)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 083621

Facility ID: 000222

If continuation sheet

Page 6 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JETIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPLI	
		155329	B. WIN	G		04/16/	2012
NAME OF D	PROVIDER OR SUPPLIER		-	STREET	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	ROVIDER OR SOLI EIER			1302 N	LESLEY AVE		
ROSEWA	ALK VILLAGE AT IN	IDIANAPOLIS		INDIAN	IAPOLIS, IN 46219		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0144	NFPA 101						
SS=F		ODE STANDARD					
		nspected weekly and					
		load for 30 minutes per ance with NFPA 99.					
	3.4.4.1.	ande with the fixed.					
	Based on record	review, observation and	K01	44	K144		05/08/2012
		cility failed to ensure			No residents were found to		
	•	er would be transferred to			have been affected by this alleged		
	" " "	enerator within 10			deficient practice.		
	0 10	ing power loss for 10 of			2. All residents in the facility had the potential to be affected by the	d	
		A 99, 3-4.1.1.8 states			alleged deficient practice.		
	generator set(s) shall have sufficient				Emergency generator was repaired		
	•	up the load and meet the			on 4/18/2012 so that transfer of		
		ncy and voltage stability			power takes place in less than 10		
	•	the emergency system			seconds.		
		ls after loss of normal			3. Emergency generator will be		
		9, 3-5.4.2 requires a			tested on a monthly basis to ensure	2	
	1 ^	inspection, performance,			power transfers within 10 seconds. If transfer takes longer than 10		
		• •			seconds, appropriate repairs will be		
	• •	l and repairs shall be			ordered immediately.		
	-	ined and available for			4. Maintenance supervisor will		
		e authority having			audit monthly on going the power		
		s deficient practice could			transfer to ensure transfer within 10	0	
	affect all residen	ts, staff and visitors.			seconds. Results will be taken to		
					CQI committee for recommendations.		
	Findings include	:			5. Systemic changes will be in		
	D 1 .	CHE			place by 5/8/12		
		ew of "Emergency					
		kly Exercise/Monthly					
	_	documentation with the					
		pervisor during record					
	review from 9:25 a.m. to 11:10 a.m. on 04/16/11, monthly load test documentation for 09/29/11, 12/31/11,						
	01/30/12, 02/29/	11 and 03/29/11 lists the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 083621

Facility ID: 000222

If continuation sheet

Page 7 of 13

PRINTED: 05/02/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155329		A. BUI	LDING	01	COMPL 04/16/	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LESLEY AVE		
ROSEWA	ALK VILLAGE AT IN	IDIANAPOLIS			APOLIS, IN 46219		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
1710		2 seconds, monthly load		1710			DATE
		on for 06/27/11 and					
		e transfer time as 13					
		load test documentation					
	_	the transfer time as 15					
	seconds and mon						
		or 04/29/11 lists the					
	transfer time as 1	1 seconds.					
	b. Based on obse	rvation with the					
	Maintenance Sup	pervisor during a tour of					
	the facility from	11:10 a.m. to 1:35 p.m.					
	on 04/16/12, whe						
	_	anually started the					
		11.5 seconds. The					
		recorded with a timer on					
		Supervisor's cellular					
	phone.						
		ew at the time of record					
		vation, the Maintenance					
	-	owledged it took more					
		to transfer building					
	of 12 months.	ergency generator for 10					
	OI 12 IIIOIIUIS.						
	3.1-19(b)						
	J.1-17(U)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 083621

Facility ID: 000222

If continuation sheet Page 8 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	a. BUILDING 01		COMPLETED	
		155329	B. WIN	G		04/16/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					LESLEY AVE		
ROSEWA	ALK VILLAGE AT IN	IDIANAPOLIS		INDIAN	IAPOLIS, IN 46219		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG K0154	REGULATORY OR NFPA 101	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
SS=F	LIFE SAFETY C Where a required	ODE STANDARD d automatic sprinkler system					
		for more than 4 hours in a he authority having					
	•	ified, and the building is					
		approved fire watch system					
	•	I parties left unprotected by					
	been returned to	til the sprinkler system has service. 9.7.6.1					
	Based on record	review and staff	K01	54	K154		05/08/2012
		cility failed to provide a			No residents were found to		
		policy containing			have been affected by this alleged		
	•	followed in the event the			deficient practice.		
		ler system has to be			2. All residents in the facility had the potential to be affected by the	1	
	•	vice for 4 hours or more			alleged deficient practice. The		
	•	od in accordance with			Disaster Plan: fire watch policy has		
	•	7.6.1 in order to protect			been amended to specify that fire		
		ents. LSC 9.7.6.2			watch will be intiated in the event		
	requires sprinkle	r impairment procedures			that the automatic sprinkler system has to be placed out of service for 4		
	comply with NFI	PA 25, 1998 Edition, the			or more hours in a 24 hr period.		
	Standard for Insp	pection, Testing and			3. When the automatic sprinkler	•	
	Maintenance of V	Water-Based Fire			system has to be placed out of		
	Protection System	ms. NFPA 25, 11-5(d)			service for 4 or more hours in a 24		
	requires the local	I fire department be			hr period, the maintenance supervisor will notify the Executive		
	notified of sprink	cler impairment and			Director and will confirm that fire		
	11-5(e) requires	the insurance carrier,			watch has been initiated. Executive		
		building owner/manager			Director or designee will inform all		
	and other authori	ities having jurisdiction			necessary entities if the facility is on		
	also be notified.	This deficient practice			fire watch.		
	could affect all re	esidents, staff and			4. Maintenance supervisor will audit for 3 months each time the		
	visitors.				automatic sprinkler system has to be	e	
					placed out of service for 4 or more		
	Findings include	:			hours in a 24 hr period that fire		
					watch was appropriately initiated		
	Based on review	of "Disaster Plan: Fire			and that all necessary entities were		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 083621

Facility ID: 000222

If continuation sheet

Page 9 of 13

IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155329	LDING	ONSTRUCTION 01	(X3) DATE : COMPL 04/16/	ETED
PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE LESLEY AVE APOLIS. IN 46219		
SUMMARY S' (EACH DEFICIEN REGULATORY OR Watch Policy and documentation we Supervisor during 9:25 a.m. to 11:1 following was not at the fire watch statement of the statement of the statement of the statement of the states "Call 911 to facility's ED or do necessary entities fire watch policy entities, which in Department of H local fire department of H local fire department of a fire Based on interview, the Main acknowledged the watch policy did the fire watch an necessary entities automatic sprink	IDIANAPOLIS FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) d Procedure" with the Maintenance g record review from 0 a.m. on 04/16/12, the oted: policy did not include a fire watch being initiated automatic sprinkler placed out of service for in a 24 hour period. "Procedure" section to report the fire. The esignee will notify all s." The facility's written stated the necessary cludes the Indiana State ealth, alarm company, ment, and building would only be notified in e. ew at the time of record tenance Supervisor e facility's written fire not include initiation of d notification to all is in the event the ler system has to be vice for 4 hours or more		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) notified. Results will be taken to the CQI committee for recommendations. 5. Systemic changes will be in place by 5/8/12		(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 083621

Facility ID: 000222

If continuation sheet

Page 10 of 13

PRINTED: 05/02/2012 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT INDIANAPOLIS IX4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DETECTIONES (EACH DETECTION OF RECEDED BY PULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE (INDIANAPOLIS, IN 46219) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE (INDIANAPOLIS, IN 46219) (XS) COMPLETION DATE			IDENTIFICATION NUMBER: 155329	(X2) MULTIPLE CC A. BUILDING B. WING	01		ESURVEY LETED 6/2012		
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				1302 N LESLEY AVE					
	(X4) ID PREFIX	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (FACH CORRECTIVE ACTION SHOL	ILD BE	COMPLETION		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 083621

Facility ID: 000222

If continuation sheet Page 11 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL [*] A. BUILDI		nstruction 01	(X3) DATE : COMPL		
		155329	B. WING	ING		04/16/	2012
	PROVIDER OR SUPPLIER			1302 N I	DDRESS, CITY, STATE, ZIP CODE LESLEY AVE APOLIS, IN 46219		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX ΓAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0155 SS=F	Where a require service for more period, the author notified, and the approved fire water left unprotected alarm system has 9.6.1.8 Based on record		K0155	5	K155 1. No residents were found to		05/08/2012
	complete written procedures to be fire alarm systen service for 4 hou period in accorda 9.6.1.8 in order t residents. This c	cility failed to provide a policy containing followed in the event the has to be placed out of ars or more in a 24 hour ance with LSC, Section o protect 151 of 151 leficient practice could ts, staff and visitors.			have been affected by this alleged deficient practice. 2. All residents in the facility had the potential to be affected by the alleged deficient practice. The Disaster Plan: fire watch policy and procedure has been amended to specify that fire watch will be intiated in the event that the fire alarm system has to be placed out of service for 4 or more hours in a 24 hr period.		
	Watch Policy an documentation we Supervisor during 9:25 a.m. to 11:1 following was not at the fire watch statement of the in the event the fire be placed out of more in a 24 hours, the fire watch	vith the Maintenance g record review from 0 a.m. on 04/16/12, the oted: policy did not include a fire watch being initiated ire alarm system has to service for 4 hours or			3. When the fire alarm system has to be placed out of service for 4 or more hours in a 24 hr period, the maintenance supervisor will notify the Executive Director and will confirm that fire watch has been initiated. Executive Director or designee will inform all necessary entities if the facility is on fire watch 4. Maintenance supervisor will audit for 3 months each time the fir alarm system has to be placed out of service for 4 or more hours in a 24 hr period that fire watch was appropriately initiated and that all necessary entities were notified.	n. e	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 083621

Facility ID: 000222

If continuation sheet

Page 12 of 13

PRINTED: 05/02/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155329	A. BUILDING B. WING	COMPLETED 04/16/2012
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN PREFIX (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE
IAU	facility's ED or designee will notify all necessary entities." The facility's written fire watch policy stated the authority having jurisdiction, the Indiana State Department of Health, would only be notified in the event of a fire. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the facility's written fire watch policy did not include initiation of the fire watch and notification to all necessary entities in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period. 3.1-19(b))	Results will be taken committee for recom Systemic changes will 5/8/12	to the CQI mendations.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 083621

Facility ID: 000222

If continuation sheet Page 13 of 13